Exhibit 24
HB 2
Exhibit 9

This exhibit is regarding HB 2. These documents exceed the 25 page maximum that can be scanned. Therefore only a small portion is scanned to assist you with research. It is from URL site http://www.ncsl.org/programs/health/SPAPCoordination.htm

The original exhibit is on file at the Montana Historical Society and may be viewed there.

State Pharmaceutical Assistance Programs in 2006-07: Helping to Make Medicare Part D Easier and More Affordable

An analysis of laws and regulations providing state-funded prescription drug wrap around benefits, coordination and ease of enrollment for 1.5+ million residents in more than 20 states. Updated with 2006 Federal Poverty Guidelines.

Updated: January 10, 2007 - Subject to additions

Summary Table of Wrap Around Plans	Emergency Gap Plans	State SPAP Details	Rx & SPAP Definitions

Many state governments play a substantial role in offering direct pharmaceutical assistance benefits to eligible residents Most commonly, individual states have offered substantial subsidies to low and moderate income seniors. About half the states include younger adults with disabilities among those eligible.

A majority of these programs are recognized within the federal Medicare Modernization Act (MMA) and are termed State Pharmaceutical Assistance Programs or "SPAPs" in the federal law.[1, 2] In the past five years, a growing number of state also offer state pharmaceutical discount programs. After 20 plus years of evolution and expansion, state pharmaceutica subsidies reach an estimated 1.8 million enrollees, while state discount programs are offered to another 5.5 million residents nationwide as of December 2005.

From the state perspective, the passage of the MMA in December 2003 presented important opportunities and benefits as well as challenges and options. The legal structure of the Medicare Modernization Act, with its emphasis on voluntary enrollment, means there is extraordinary opportunity for state flexibility in connecting the state's voluntary programs to the new federal program.

This report analyzes the diverse steps taken by individual states to adjust existing subsidy programs to better fit with th Part D Medicare prescription drug benefits that became available on January 1, 2006. It also includes programs newly created in 2005-06 that are designed to coordinate with Part D benefits. More than 1.5 million beneficiaries will be eligible for these state subsidies in at least 20 states. In broad terms, the legislative actions taken so far seek to combine or select among several goals:

1. **Providing state funds to enhance or supplement Medicare Part D prescription drug coverage for selected state residents, a strategy commonly termed "wrap around benefits."** For example, New York's EPIC program is paying for deductibles, co-insurance or copayments, the gap in coverage above $2,250 and pharmaceuticals not covered by Medicare. At least 16 states committed to this approach, most beginning on January 1, 2006. In addition, five states enacted first-time subsidy programs that focus entirely on wrap around or supplementing MMA benefits: Alaska, Hawaii, Kentucky, Montana and New Hampshire. Not all programs are operational.
2. **Emergency transition or "gap coverage" for dually-eligible enrollees who are denied service at pharmacies due to record-keeping flaws or other eligibility processing issues.** In quick response to problems at pharmacy counters, at least 37 states created temporary authorization to cover claims that should b eligible for Medicare payment eventually. These states include Alabama, Alaska, Arizona, Arkansas, California, Connecticut, District of Columbia, Hawaii, Idaho, Illinois, Kansas, Maine, Massachusetts, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont and Wisconsin which acted prior to the federal announcement of state reimbursement. By April at least 11 additional states joined after the HHS announcement. The actual state role

varies considerably. Online: **Emergency Gap Plans, 2006**.

3. **Redirecting some state-funded pharmaceutical program services to populations not covered by Medicare.** Examples of newly enacted Rx plans aimed at under-65 adults or families include Arkansas, Illinois, Maryland, Montana, New Mexico and Oklahoma.[4]
4. **Reducing or eliminating benefits previously included in state SPAP programs that will now be coverec by Medicare Part D.** Almost all programs reduced or eliminated those 2005 state benefits that are now fully available through the federal program. Most enrollees did not see their coverage reduced as a result. For example, as of January 1, Part D beneficiaries in the lowest-income tier (under 135 percent of federal poverty or $12,919 annually for '06) have no premiums or coverage gaps. In other examples, Missouri requires state enrollees over 150 percent to use Part D instead of the state program; Wyoming dropped Medicare eligibles as of June 2006 and continues coverage for those not allowed in Medicare. Delaware requires Part D enrollment in order to receive a state subsidy, while the effective date for being in a Part D plan was pushed back to March 31, 2006.
5. **Terminating the state-funded program.** Five states elected the termination approach, including Florida, Kansas, Michigan, Minnesota, and North Carolina, generally because the state-only program offered benefits very similar to the 2006 Medicare choices.

State Timetables: The two-year implementation period (between passage of the law in December 8, 2003 and Januar 1, 2006) provided a relatively short time for state legislatures and executives to change and update their state programs. In 2004, quite a few states moved quickly to work with the temporary Medicare Discount Card program. Several states initiated the idea of automatic enrollment of state beneficiaries into Medicare Discount Cards with state benefits coordinating with the federal discount, and ultimately reported substantial success in signing up Medicare-eligible residents. However, in 2004, prior to federal rule-making affecting many aspects of Part D implementation, it was not possible for individual states to design and enact more permanent coordination plans focused on benefits that would begin in 2006.

In most states, active planning and legislative activity began when the federal Final Regulations, promulgated on Januar 26, 2005, provided a firm legal basis for redesigning or initiating state pharmaceutical programs. With 32 states scheduled to meet and complete legislative sessions before July 1, 2005, most legislatures had only three to five month: to consider and act on SPAP changes. While recognizing that Medicare enrollees were not compelled to enroll in Part D but instead would choose to enroll or not, an extraordinary number of states chose to enact laws coordinating their programs with the Medicare Program-- at least 28 states by one definition. [5]

Wrap around and Coordinated Benefits: The most notable SPAP changes are so-called "wrap around" benefits. Generally this approach allows for combining a set of federally-funded benefits with another package of state-funded benefits, enabling the enrollee to pay lower out-of-pocket charges for prescriptions than with the federal program alone, or to receive a type of drug not available through Medicare. The Part D benefit design is complex and MMA allows for variability among Medicare Part D drug plans. Even before specific drug plans were approved by the federal government, states assessed which "wrap around" features would be most important or desirable. Virtually all of the 2005 state laws detailed in this report were enacted before the PDP's unveiled their plan designs, formularies, or premium structures.[7]

For states with operational SPAPs prior to 2005, some common elements of 2005 legislation were to:

1. Use state resources to pay part or all of the $250 annual deductible for selected Medicare beneficiaries;
2. Use state resources to pay part or all of the Part D monthly premium (estimated to average $32 per month) for selected Medicare beneficiaries;
3. Use state resources to pay part of the patient per-transaction copayment or coinsurance for selected Medicare beneficiaries;
4. Use state resources to pay part of or the entire coverage gap ("doughnut hole") from $2,250 to $5,100 for selected Medicare beneficiaries.
5. Cover pharmaceutical products excluded from coverage by Medicare Part D or not included in formularies of individual Part D plans. The Medicare Excluded Drug Categories are fertility, weight loss, cosmetic, birth control, barbiturates, benzodiazepines, hair growth, vitamins and Over-the-Counter products;

6. Require enrollment in Part D as a condition of receiving state benefits, or authorize voluntary automatic enrollment into locally available Part D plans.

As noted above, least five states without state-funded programs at the end of 2003 created new SPAP-style programs in 2005, with fairly similar goals or features. Separately, six states launched pharmaceutical programs for non-Medicare populations. These are described in a separate NCSL report.

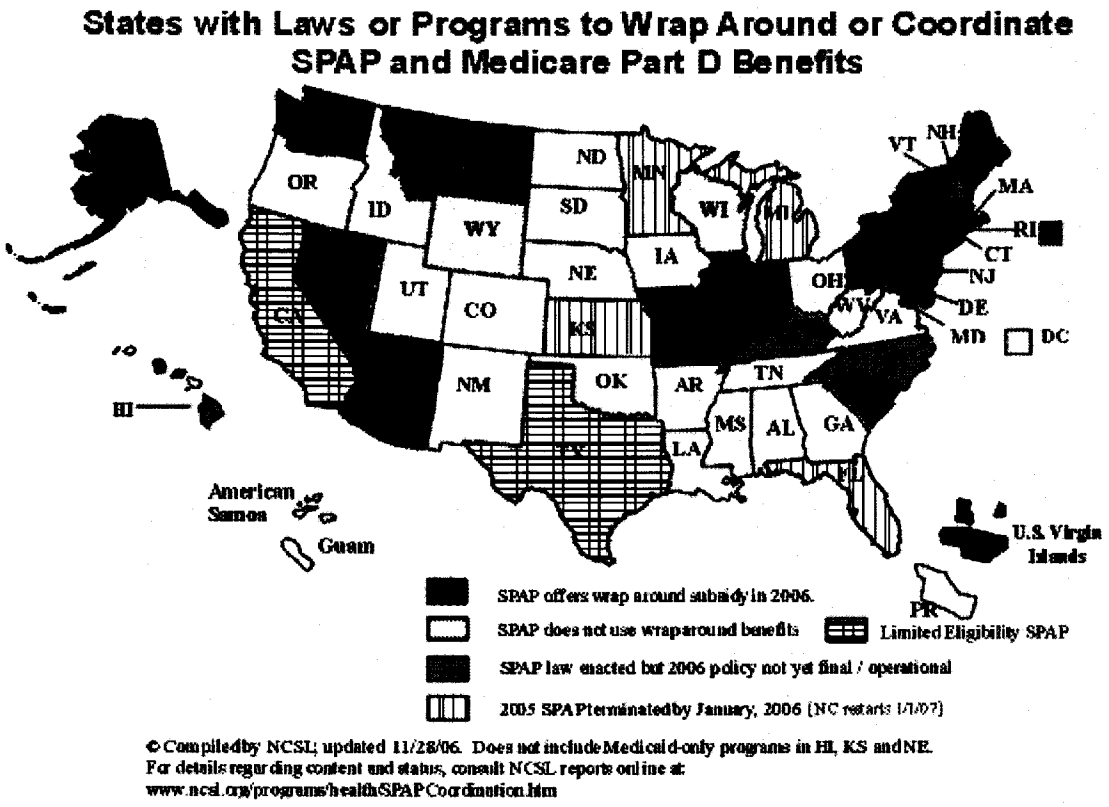
How to Use this Report

The November 2006 edition of this report is an updated work-in-progress. Much of the information provided is based on laws enacted in 2005-06, and includes some provisions not yet implemented as of the completion of research on this report. Some features authorized by state law may not be available or implemented for 2006. Individual state descriptions reflect the best available information as of the dates noted, and are intended for comparative use by policymakers, researchers and others involved in state-level activities.

Medicare Enrollees: Individuals eligible for Medicare and others are welcome to read and use this report for general information. Please use the state-level charts at "**State**," with web links and telephone numbers included below for additional help in understanding specific state assistance, including application forms and telephone helplines. Many state programs have additional terms and conditions not described in the brief summaries listed below. Information will be expanded in future editions; please revisit the online edition for the latest material.

Disclaimer: This report is not intended as an official consumer guide or an offer of state-funded services. NCSL is not responsible for the availability or unavailability of benefits to individual residents, or for information contained on third-party web pages.

Map of State SPAP Programs



© Compiled by NCSL; updated 11/28/06. Does not include Medicaid-only programs in HI, KS and NE.
For details regarding content and status, consult NCSL reports online at:
www.ncsl.org/programs/health/SPAPCoordination.htm

A closer look at two states (in Table 1) serves as an example of the various components of state approaches.

TABLE 1 – Examples of Coordinated benefits for an individual over 150% of FPL[3] (over $14,700 for 2006)

This table uses Illinois and Nevada as illustrative examples of wrap around benefits. Details for other features and other states are provided in part 2 of this report.

FEATURE	MEDICARE limit on coverage (Enrollee out-of pocket)	ILLINOIS wrap around (as of Jan. 2007)	NEVADA wrap around (as of Jan. 2007)
Stated goal	n/a	Enrollees "continue to receive equivalent coverage..."	Maintain present coverage "to the extent allowed by federal law.
Deductible	Pay first $250 per year (some plans = $0-$150)	State pays SPAP covered drugs from first dollar.	No state contribution.
Monthly premium (typical examples)	Pay average of $386 per year.	State pays 100%; also eliminates state premium of $5 to $25.	State pays 100%, up to $281.52 annually.
coinsurance or copay (brand example)	Pay 25% of cost.	State pays 100% of copayment over $5.	No state contribution.
coinsurance or copay (generic)	Pay 25% of cost.	State pays 100% of copayment over $2.	No state contribution.
Coverage gap $2250 -$5100 each year	Pay 100% out-of-pocket (up to $2,850.)	State pays 80% for Rx over $1,750.	State pays 100% above copayments of $10 for generics or $25 for preferred brand name.
Catastrophic coverage	Pay 5% copayment.	None (state pays same 95% as Medicare.)	State pays up to $5,000 maximum annually.
New state requirements for enrollees	n/a	Must enroll in Part D plan if eligible; must apply for low-income subsidy.	If eligible for Medicare low-income subsidy must apply and use it.
Affected population	All Medicare eligible persons.	241,000 eligible for Medicare plus 33,800 not eligible for Medicare.	9,500 estimated eligible. Non-Medicare eligible will get state-only help.
Statutory Authority	Medicare Modernization Act, Dec. 2003.	Illinois SB 973 of 2005.	Nevada AB 495 and AB 524 of 2005.

STATE OPTIONS AND CHALLENGES

Coverage for Non-Elderly Persons with Disabilities. For a number of years, some state-only Rx programs included some non-elderly adults with disabilities—that is, non-elderly persons who qualify for Social Security Disability Insurance (SSDI)—while others covered elders only. The MMA Part D benefit is linked to eligibility for Medicare and, for younger persons on SSDI, is available only after a beneficiary has met a two-year waiting period for Medicare eligibility. This presents special challenges to states where eligibility for state pharmaceutical benefits is acquired sooner through eligibility for SSDI alone. Several states (CT, DE, IL, ME, MD, MA, NV, NJ, RI, VT) will continue to use the broader definition—eligibility for SSDI—for state pharmaceutical benefits. [List updated 2/10/06.]

Residence, Citizenship and Alien Status. Some existing state pharmaceutical programs do not require the same standard of documented status for non-citizens as Medicare. Low-income state residents who are ineligible for Medicare due to citizenship or alien status require special attention in redesigned state programs to specify their eligibility status for state-only benefits in 2006 and beyond. For example, states like Illinois specify that such residents are eligible; in Missouri they will be ineligible; in Alaska they could get a non-federal pharmaceutical plan wrap around benefit. The new, higher standard of proof of citizenship for Medicaid, effective July 1, 2006 also may have an effect of shifting some enrollees to state-only programs.

Changing Income Levels of Enrollees. Virtually all state programs include specific income eligibility maximums, such as 175% or 200% of the federal poverty guidelines, often termed the "FPL." The federal Part D benefit is available to al Medicare beneficiaries with no income limit but offers additional financial assistance to persons with incomes under 150%

of FPL. State SPAP enrollees at or close to an income maximum may face complex situations if their monthly or annual income changes by a few dollars. They might lose wrap around benefits in mid-year if so defined in state law, or lose federal extra help while remaining in a state program and even be able to receive a higher amount from their state. NOTE: On January 24, 2006 the 2006 poverty guidelines were released, providing about a 2.4 percent increase for individuals compared to 2005.

Medicaid Program Changes. All 50 state Medicaid programs had to adjust to the transfer of dual-eligible Medicare-Medicaid enrollees to Medicare coverage, meaning Medicaid no longer administer this part of the benefit as of January 1, 2006. State Medicaid budgets will continue to pay 90 percent of the cost of dual-eligible pharmaceuticals through the phased-down state contribution, sometimes termed the "clawback."

State Medicaid programs can claim federal matching funds for coverage of Part D excluded drugs for dual eligibles. HHS has determined that if a state provides coverage of any excluded drugs to its non-dual eligible Medicaid population, it must provide that same coverage to its dual eligibles. In addition, states may use state-only funds to offer wrap around coverage to dual eligibles for additional (for example, non-excluded) drugs not included by Medicare drug plan formularies. States may provide this supplemental coverage through their Medicaid program or through a State Pharmaceutical Assistance Program (SPAP).

NEW 10 states report Medicaid agency ongoing involvement in co-payment assistance for dual-eligibles, as noted in Table 2 below. Other Medicaid agency benefit changes are beyond the scope of this report, but will be described in future publications.

An HHS survey of 47 state Medicaid programs in December 2005 showed that 45 Medicaid programs will continue to cover non-prescription drugs, 46 states will cover benzodiazepines, 45 states will cover barbiturates, 35 will cover prescription vitamins and mineral products and 32 states will cover drugs for symptomatic relief of cough and colds. [Source: DUAL ELIGIBLES' TRANSITION: PART D FORMULARIES' INCLUSION OF COMMONLY USED DRUGS, Office of the Inspector General, HHS, January 2006].

Summary of Major State Features: Table 2, directly below, summarizes the major features of state pharmaceutical assistance programs designed to wrap around Part D. The Table describes programs in more than 20 states. Data is based primarily on state laws enacted in 2005-06, plus more recently established state policies, and may not reflect exceptions for certain populations, sliding scale benefit variables and late-breaking regulatory requirements promulgatec after January 2006. Any enacted law changes will be added to future editions of this report. Two states, Kansas and Nebraska, do not have SPAPs, but are reported to provide wrap around assistance only to dual-eligibles through the Medicaid agency and are included in the tables below.

TABLE 2
STATES PROVIDING OR AUTHORIZING ADDITIONAL, SUBSIDIZED "WRAP AROUND" BENEFITS TO MEDICARE ENROLLEES IN 2006

STATE	Qualified status	Wrap around authorized by	Maximum income, individual (% of '06 Federal Poverty)	Premium help	Deductible help	Copayment help	Coverage gap (>$2,250) help	Moderate income help 250+% FPL	Persons with Disabilities under age 65	Automatic-enrollment authorized
Alaska	SPAP, M	'05 law, new	175%	**Yes**	**Yes**	No	3	No	No	
Arizona NEW	Non	'06 law, new	200%	No	No	**Yes**	No	No	**Yes**	
Connecticut	SPAP, M	'05 law	218.3%	**Yes**	**Yes** 1	**Yes** 1	**Yes** 100%	No	**Yes**	**Yes**
Delaware	SPAP, M	'05 law	200%	**Yes**	**Yes**	No	**Yes**	No	**Yes**	
Hawaii	Non Medicaid	'05 law, new; Not operational '06 Medicaid	100% 150%	**Yes** 2,3	**Yes** 2,3	**Yes** 3 **Yes** 7	**Yes** 2,3	No	**Yes** **Yes** 7	Facilitate

		regs.								
Illinois	SPAP+	'05 law	216.5%	**Yes**	**Yes**	**Yes** 1	**Yes**	No	**Yes**	
Indiana	SPAP, M	'05 law, '06 regs.	150%	**Yes** 5	No 5	No 5	No	No	No	**Yes**
Kansas NEW	Medicaid	'06 Medicaid regs.	135%			**Yes** 7			**Yes** 7	
Kentucky	Non	'05 law, new Not operational	150%	**Yes** 3	**Yes** 3	**Yes** 3	**Yes** 3	No	**Yes** 3	
Maine	SPAP, M	'05 law	185%	**Yes**	**Yes**	**Yes** 1	**Yes**	No	**Yes**	
Maryland	SPAP	'05 law	300%	**Yes** >$10	**Yes** 100% 3	**Yes** 3	Yes 3	**Yes** 300%	**Yes**	**Yes**
Massachusetts	SPAP, M	'05 law	500%	**Yes**	**Yes**	**Yes**	**Yes**	**Yes** 500%	**Yes** 188%	**Yes** 5
Missouri	SPAP, M	'05 law	200%	**Yes**	**Yes**	**Yes**			**Yes**	**Yes**
Montana	SPAP	'05 law, new	200%	**Yes**	**Yes**	No	No	No	**Yes**	
Nebraska NEW	Medicaid	'06 Medicaid regs.	135%			**Yes** 7			**Yes** 7	
Nevada	SPAP	'05 law	236.4%	**Yes**	No	No	**Yes**	No	**Yes**	
New Hampshire	Non	'05 law, new; Not operational	150%	**Yes** 2,3	**Yes** 2,3	**Yes** 2,3	**Yes** 2,3	No	**Yes**	**Yes**
New Jersey	SPAP	'05 law	316.2%	**Yes**	**Yes**	**Yes**	**Yes**	**Yes** 316%	**Yes**	Option
New York	SPAP	'05 law	357.1%	No	**Yes**	**Yes** 1	**Yes**	**Yes** 357%	No	Facilitate
North Carolina NEW	SPAP	'06 change	175%	Yes	No	No	No	No	No	
Pennsylvania	SPAP	'06 law	240%	**Yes**	**Yes**	**Yes** 1	**Yes**	No	No	**Yes**
Rhode Island	SPAP	pending	392%	4	**Yes**	4	**Yes**	**Yes** 392%	No	
South Carolina	SPAP	'05 law	200%	No	No		**Yes**	No	No	Facilitate
Vermont	SPAP+	'05 law	225%	**Yes** 1	**Yes**	**Yes**	3	No	**Yes**	**Yes**
Virginia	SPAP	'06 program								
Washington	Non	'06 law		No	No	**Yes**	No	No		No
Wisconsin	SPAP+	'05 waiver	240%	No	No		6	No	No	No

OTHER STATE PROGRAMS WITH SOME WRAP AROUND FEATURES

Maryland - KDP	SPAP		none		**Yes**	**Yes**	**Yes**			
Texas - KHC	SPAP		150%	**Yes**	**Yes**	**Yes**		No	**Yes**	No
Washington - WSHIP	SPAP		none	**Yes** 8	**Yes** 8	**Yes** 8	**Yes** 8			

This summary table does not include all Medicaid program benefits. See note 7 below

1 – State can or will pay the portion that is higher than the standard state copayment or premium.

2 – Applies primarily to non-dual-eligible enrollees up to 150% of FPL, or duals between 135% and 150%.

3 – May be authorized in statute, but not currently established as a benefit.
4 - Under review or not yet determined.
5- Indiana changed benefits as of 7/1/06, to provide premium payments but no longer provide copayments and deductibles.
6 - Because of its 1115 Pharmacy Plus waiver, valid through 2007, WI does not describe its benefit as a wrap around. Enrollees over 200% FPL may be able to obtain benefits for expenses above $2,250.
7 - Benefits are limited to Medicaid-Medicare dual-eligible enrollees only; administered by Medicaid agency, not an SPAP See Table 3 below.
8 - FCHA and WSHIP are offered only to uninsurable residents. Enrollees must pay a substantial monthly premium for health insurance in order to obtain this wrap around coverage.

Table 3
INDIVIDUAL STATE SPAP FEATURES AND WRAP AROUND PROVISIONS

The states and programs listed in the following tables will offer state-funded pharmaceutical services as of January 1, 2006, or are engaged in negotiations to offer such services. Most of the information provided is based on signed laws enacted in 2005, but not yet implemented as of the completion of research on this report. Some features authorized by state law may not be available or implemented for early 2006.

ALASKA	**Senior Care Prescription Drug Benefit Program**
Alaska is one of five states to create a first-time pharmaceutical subsidy program after the enactment of th MMA. As such, it is intended primarily as a supplemental, wrap around benefit, aimed only at residents aged 65 and over, with incomes up to 175% of Alaska's special FPL. The law authorizes the state to pay premiums and deductibles toward Part D plan costs or toward equivalent insurance premiums.	
State laws – 2004 & 2005	First subsidy enacted in 2004; Wrap around enacted in HB 106, as Chapter 89, signed August 8 2005. Text: http://www.legis.state.ak.us/PDF/24/Bills/HB0106Z.PDF Program effective date: January 1, 2006.
State eligibility NEW	Residents age 65. For SeniorCare Cash Assistance, income limit is $16,133 for an individual and $21,641 for a 2-person household; liquid assets must be below $6,000 for an individual an $9,000 for a couple. For SeniorCare Prescription Drug Assistance, income limit is $20,913 for an individual and $28,053 for a 2-person household.
Disabilities coverage	Persons with disabilities under age 65 are not eligible for state benefits.
Benefit example NEW	Under the Cash Assistance program, qualified residents can receive $120/month cash assistanc (up to $1,400 annually). Under the Prescription Drug Assistance program, qualified residents can receive up to $670 for annual premiums and deductibles for Medicare or comparable insurance.
Emergency gap coverage - 2006	Medicaid may cover one 30-day transitional supply, between 1/1/06 and 3/31/06.
Special Features	AK will pay the same premium and deductible share toward employer retiree plans.
Requirements & Limits	If state funds are "insufficient", the state may reduce or eliminate payments, first for deductibles, then premiums. A "sister" cash assistance program for seniors up to 135% FPL ha first priority for funds. Individuals must be enrolled in some type of Rx plan – includes Part D PDP or Medicare Advantage; also group health, FEHBP, VA, Medigap or "any other private plan" identified by the state as equivalent to a Part D plan. A person with no premium or deductible cannot receive benefits; this disqualifies Medicare enrollees with income under 135% of FPL. Disabled under age 65, or residents in institutions or nursing facilities, are not eligible. Residents with income under 135%% FPL (about 7,000) are eligible for up to $1,440 annual direct cash benefit, not earmarked for Rx, but available to use for special assistance low income copays of $1-$5. Asset limit is $50,000 (individual) and $100,000 (couple).
SPAP legal status	Qualified SPAP approved by CMS; payments count toward enrollee TrOOP, 10/05.
Est. # of Beneficiaries NEW	122 enrolled in Prescription Drug Assistance program as of 7/1/06.

	7,112 enrolled in the Cash Assistance program ($120/month subsidy) as of 7/1/06.
Funding source	State law creates the Alaska Senior Care Fund, based on transfer of any 2004 funds and future annual state appropriations.
2006 & Future issues	Parts of the SeniorCare program sunset in June 2007 unless extended by the legislature. Annual funding is subject to available funds and legislative appropriations. 2005 estimates included 7,000 seniors served by the Cash Assistance program and 4,000 seniors served by the Prescription Drug Assistance program. The Department will be assessing enrollment figures in August 2006. NEW
Contact & Information Web site	Alaska Department of Health and Social Services Policy & Admin. Contact: Sherry Hill, (907) 465-1618, Cell (907) 321-2838 Beneficiary Contacts: 1-800-478-6065 (Anchorage 907-269-3680.) www.hss.state.ak.us/dsds/seniorcaresio.htm

Updated: 11/27/05; 12/29/05; 7/28/06
Sources: Governor's office 12/05; SeniorCare website 12/20/05 & 7/28/06; interview with Sherry Hill 7/28/06.

ARIZONA	**Medicare Copayment plan** NEW
In June 2006, FY 2006-2007 budget bill includes $1.5 million appropriations for payment of Part D copays for dual eligible enrollees, including acute, long-term care and behavioral health, administered by AHCCCS, the Medicaid agency. "The intent of the Legislature is that all Part D copayments will be covered as a state subsidy." Program begin: October 1, 2006	
State law(s)	HB 2863, signed as Chapter 344, 6/21/06 - FY 2006-2007 budget bill includes $1.5 million appropriations for payment of 100% of the Part D copays for dual eligible enrollees, including acute, long-term care and behavioral health, administered by AHCCCS, the Medicaid agency. "The intent of the Legislature is that all Part D copayments will be covered as a state subsidy."
Eligibility	Medicaid dual-eligibles, up to 200% of federal poverty. Medicare Part D enrollment is required but separate state enrollment in the copayment plan is not required. **The program will be operational as of October 1, 2006**
Benefits	AHCCCS will pay for 100% of the $1 to $5 pharmaceutical copayments for residents enrolled ir both Medicaid and Medicare.
Special features	No special enrollment is required for dual-eligibles once enrolled in Mediaid and Medicare. Arizona also continues to offer the CoppeRx Card® Prescription Discount Program- see below
Est. # of beneficiaries	An estimated 87,000 dual-eligibles will be eligible. (9/06)
2006 and future issues	Arizona also continues to offer the CoppeRx Card® Prescription Discount Program, a plan created by Governor Napolitano "to provide significant discounts on prescription drugs for all Arizona residents." Claimed savings "typically range from 15% to 55% from the overall retail price." The program is run by RxAmerica, a subsidiary of Longs Drug Stores, but purchases may be made at more than 500 community-based and chain pharmacies. There is no enrollment fee to participate. There were 1,100,000 residents with cards
Contact information NEW	Arizona Health Care Cost Containment System (AHCCCS) Toll-free: 800-770-8014; policy: 602-417-4269 http://azahcccs.gov/site/ http://www.azahcccs.gov/PublicNotices/PressReleases/PR_MedicarePartD.pdf (9/21/06)

CONNECTICUT	**ConnPACE** (Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled)
Connecticut's long-time subsidy program, ConnPACE, is authorized to wrap around and coordinate benefits between ConnPACE and MMA, including allowing the state to apply on behalf of current state subsidy	

enrollees. All enrollees eligible for Medicare must join Part D, with the state covering all premiums, all but $30 of the deductible, and costs above the $2,250 gap.

State law(s)	1986: Program established by CGL sec 17b-491 et seq. 2005: Public Act 05-280, signed June 27, 2005.
State eligibility	Resident with annual income up to $22,300 for an individual; $30,100 for a married couple, who is 65 or older or who is over age 18 and disabled ($ as of mid 2005). Must have "no othe plan of insurance or assistance" except Medicare Part D. A $30 annual registration fee required. An annual inflation adjustment is tied to Social Security income, to the nearest $100.
Disabilities coverage	Persons with disabilities between the ages of 18-64 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefit example	The state will pay 100% of the Part D premiums (average $370 year,) plus all out-of-pocket coinsurance and deductible above the standard ConnPACE $30 annual fee and copayment requirement of $16.25 per prescription. There is no yearly dollar limit on the amount of prescriptions covered. A person with $5000 in annual Rx expenses might receive up to $3,50(in state-funded benefits.
Emergency gap coverage - 2006	Special law passed Dec. 2005 provides that the Commissioner of Social Services may be the authorized representative of a full benefit dually eligible Medicare Part D beneficiary for the purpose of enrolling the beneficiary in a Medicare Part D plan and may pay all copayments.
Special features	The Program will cover products "that are not Part D drugs" as defined in the MMA, if the patient or prescriber appeals for an "exception." The state payment rate "may be made at (A) the lowest price established" by a PDP for a preferred drug in the same class, with the beneficiary responsible for any higher balance; (B) the ConnPACE price if lower than the PDP price. Authorizes automatic application for low income subsidy benefit and state-initiated enrollment in Part D plans, with the state selecting a Part D plan designated by the Commissioner if a recipient has not done so. Provides that the applicant or recipient "shall appoint the (state) commissioner" for the purpose of appeals and denials. Full SPAP benefits are available until an individual is enrolled in Medicare Rx. Once enrolled, SPAP will provide wraparound coverage.
Requirements & Limits	Enrollment in Part D is a requirement for all who are eligible, as of 1/1/06. The State now requires asset as well as income reporting beginning July 1, 2005. The State will not provide coverage for drugs purchased outside of the formulary for the selected PDP.
SPAP legal status	Qualified SPAP approved by CMS; payments count toward enrollee TrOOP, 10/05.
Est. # of beneficiaries	49,396 enrolled as of June 30, 2005; estimate 48,000 are both Medicare + ConnPACE enrolled
Funding source	For FY 2004 ConnPACE's offset program costs by receiving $1,569,360 in fees from participants and $32,009,150 from drug manufacturers, for a net cost of $60,517,110 from state revenue funds.
2006 & future issues	All SPAP members are slated to be enrolled by 5/15/06.
Contact & information Web site	Connecticut Department of Social Services Pharmacy Unit, Medical Care Administration Medicare Part D information-English | Spanish toll-free eligibility information: 1-800-423-5026 or 860-832-9265 http://www.connpace.com/

Updated: 6/30/05 & 11/27/05
Sources: http://www.connpace.com/pubs/SFY05Annual.pdf

DELAWARE	**Delaware Prescription Drug Assistance Program (DPAP)**

Delaware's six-year old subsidy program has established a wrap around benefit for Medicare enrollees, to cover premiums, deductibles and drugs purchased in the coverage gap over $2,250, up to a maximum of

$2,500 in state funds per calendar year.	
State law(s) 1999 to 2005	1999: SB 6; benefits and enrollment began in 2000; benefits are coordinated with the private Nemours Foundation prescription benefit; their enrollees are not eligible for DPAP. 2005: SB 18 established the wrap around program, effective January 1, 2006.
Eligibility	Must be residents, at least 65 years old or qualify for Social Security Disability benefits. Maximum income eligibility limit is set at 200% of the Federal Poverty Level (FPL). Couples are counted as two individuals. Individuals with income over 200% of FPL can qualify if they have prescription costs exceeding 40% of their income.
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefit example	An individual with $5,000 in prescription costs annually could receive $370 for premiums, $25(for the annual deductible and up to $1,880 for gap coverage for a total up to $2,500 in state funds.
Special features	Requires that the Medicare benefit will be the primary source of benefits for those who are eligible for it. An original requirement to enroll in Medicare Part D by 12/31/05 was extended to 3/31/06. [News article 1/4/06] The state law restricts covered drugs to those from manufacturers that agree to provide a drug rebate back to the state, based on Medicaid rebate methodology. *[NOTE: This rebate requirement is not consistent with the structure of Medicare PDP plans.]* May cover some drugs that are excluded from Part D that have received prior authorization, including OTC drugs, benzodiazepines and barbiturates.
Requirements & Limits	DPAP provides up to $2500 per individual per calendar year. Beneficiaries must enroll in Medicare by March 31, 2006 to be eligible for DPAP payments. They must copay $5 or 25% of the cost of each prescription, whichever is greater; the state will not pay any portion of Medicare Part D copayments.
SPAP legal status	Qualified SPAP approved by CMS; payments count toward enrollee TrOOP, 10/05.
Est. # of beneficiaries NEW	9,684 enrollees as of 7/1/06; an estimated 95% are eligible for Medicare.
Funding source	Tobacco settlement funds.
2006 & future issues	The state requirement for a manufacturer drug rebate on all reimbursed products may require reexamination under federal law.
Contact & information Web site	The Division of Social Services Phone: 255-9500 or 1-800-372-2022 FAX: (302) 255-4454 http://www.dhss.delaware.gov/dhss/dss/dpap.html

Updated 12/12/05, 1/4/06 & 7/13/06.

HAWAII	**State Pharmacy Assistance Program**
Hawaii established its first subsidy program in July 2005. The program is focused on Medicare eligible seniors and persons with disabilities only with income up to 100% of FPL. ($9,800 /year in January 2006). It will assist eligible individuals "in defraying their cost" of prescriptions through a wrap around benefit within Medicare Part D. The program is not yet operational.	
State law(s)	2005: SB 802, signed on 7/8/05 as Act 209; authorized to be operational as of 1/1/06.
Eligibility	1) Residents age 65 and over or disabled with annual income up to 100% of FPL ($11,270 in 2006.) The statute does not specify Medicare eligible as a state eligibility requirement.
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, once they fully qualify for Medicare after the federal two-year waiting period.
Benefit example	A senior not on Medicaid with income just under 100% FPL might receive coverage for copayments due on each purchase.

Emergency gap coverage - 2006	State covers prescriptions when Medicare payment cannot be adjudicated. [2]
Special features	The program may facilitate enrollment and coordination of benefits. The law specifies that the program "may pay all or some of the deductibles, co-insurance payments, premiums and copayments." Most dual eligibles under 150% FPL will have limited financial obligations under Medicare Part D. Legislative Note: The final Senate legislation to create an SPAP provided for coverage up to 150% of FPL. A conference committee reduced that number to 100% FPL. The matter may be subject to further action in 2006.
Requirements & Limits	**This program is not operational as of July 2006** and the start date is not yet established. Enrollees must meet an asset test "as defined by the MMA", and not be enrolled in a Medicare Advantage plan, a retired employee plan receiving a Medicare benefit payment, or any private sector plan or insurance paying for prescription drugs. Hawaii already uses 100% FPL as the Medicaid aged-disabled level, so few, if any, state benefits may be available to Medicare enrollees.
SPAP legal status	Not currently certified as a qualified SPAP; payments do not count toward enrollee TrOOP according to CMS, as of 11/8/05.
Est. # of beneficiaries	n/a
Funding source	Earmarks all manufacturer rebates established by the 2005 Act (in sec. 346B(g)) for use by the new program.
2006 & future issues	The program is not yet operational for 2006. The low 100% FPL maximum income had been 150% FPL in the legislation, and might be revisited by the legislature. The manufacturer rebate feature, the funding source and the asset test may require reexamination to comply with CMS and PDP structures.
Contact & information Web site	Department of Human Services Policy information only: (808) 692-8134

Updated: 12/15/05; 3/28/06
Sources: HI SB 18 (CD 1); Interview with Dept of Human Services 12/05

ILLINOIS	1) **Illinois Cares Rx Plus** (formerly SeniorCare) 2) **Illinois Cares Rx Basic** (formerly Circuitbreaker)
A 2005 state law updated three existing state pharmacy assistance programs and created the "No Senior or Person with Disabilities Left Behind" plan as a Medicare wrap around that allows the state to pay premiums deductibles and gap coverage for up to 241,000 seniors and persons with disabilities. The state also will continue coverage programs for non-Medicare adults.	
State law(s)	2005: SB 973, signed 6/29/05; effective 1/1/06 IL also has had a Pharmacy Plus Medicaid 1115 waiver for certain residents under 200% of FPL.
Eligibility	Illinois Cares Rx Plus is available to residents age 65 or older, with income up to $19,600 for individuals or $26,400 for a married couple. (200% FPL as of 2/06). Illinois Cares Rx Plus will cover prescription drugs that were previously covered by SeniorCare, including some drugs that are excluded from Medicare coverage by law such as benzodiazepines. Illinois Cares Rx Basic is available up to $21,218 for individual, up to 28,480 for a couple (approximately 216% FPL), or up to $35,740 if you are filing an application for you, your spouse and one other qualified additional resident or for you and at least two qualified additional residents.
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.

Benefit example	A senior with annual income above 150% of federal poverty with $5,000 in drug expenses could receive 100% of the standard Part D premium and deductible costs, including the 25% co-insurance and gap coverage, totaling about $3,000 in state-paid costs.
Emergency gap coverage - 2006	By Governor's order of Jan. 11, 2006, Illinois Department of Healthcare and Family Services will take calls on its pharmacists' hotline about problems druggists are having filling prescriptions for low-income seniors and disabled people. If the problem cannot be resolved by phone, pharmacists will be allowed to bill the state for the cost of the drugs. The state later will seek reimbursement from private insurers that are supposed to handle the claims. News article 1/12/06
Special features	State law authorizes auto-assignment; 2005 state enrollees will be automatically enrolled in wrap around features, with one application for all programs; the state will use its preferred drug list where applicable. The state's Pharmacy Plus 1115 waiver presents special conditions for some enrollees under 200% of FPL. IL has two qualified SPAPs for TrOOP calculations.
Requirements & Limits	Enrollees with incomes between 200% and 225% of FPL are covered only for drugs for treatment of 11 conditions including: Alzheimer's, arthritis, cancer, diabetes, glaucoma, cardiovascular disease, lung and smoking-related diseases, osteoporosis, Parkinson's or multiple sclerosis. All Illinois Cares Rx clients enrolled in a PDP must follow their PDP's formulary. "Illinois Cares Rx will not cover Part D covered drugs just because they are not on the client's PDP's formulary." People with Original Medicare must apply for Low Income Subsidy ("Extra Help") and must enroll in one of two Medicare prescription drug plans coordinating with Illinois Cares Rx: PacifiCare Saver Plan or the AARP Medicare Rx of United HealthCare Insurance Company.
SPAP legal status	Qualified SPAP approved by CMS; payments count toward enrollee TrOOP, 10/05
Est. # of beneficiaries NEW	247,592 enrollees as of 6/30/06.
Funding source	State general funds.
2006 & future issues	A participant must reapply to Illinois Cares Rx before July 2006 to continue receiving benefits in 2007.
Contact & information Web site	Telephone 217 524-0084; In IL, toll-free 800 624-2459 http://www.illinoiscaresrx.com/ NEW http://www.cbrx.il.gov/ Illinois Rx Buying Club Member Services toll-free 866-215-3462 (TTY) 866-215-3479 http://www.illinoisrxbuyingclub.com/

Updated: 12/15/05, 3/1/06 & 7/13/06.
Sources: SB 973 and Bill Analysis (5/24/05); Governor's new release (7/1/05); Scott McKibbin presentation to NCSL, 12/8/05; Governor's office (7/11/06).

INDIANA	**HoosierRx**
The Hoosier Rx program, founded in 2000, continues in 2006. The current structure provides up to $1,200 per year for seniors age 65 and over with annual incomes up to 150 percent of federal poverty guidelines. The program now offers wrap around benefits for Medicare PDP monthly premiums for plans working with HoosierRx and a $250 annual allowance to use towards any deductible and/or co-pays. These changes are not yet in state statute.	
State law(s)	HB 1251; HB 1325 (2005); IN Admin. Code, Title 405, Art. 6
Eligibility	Must be a resident, age 65 and older, have Medicare Part A and/or Part B, and have a yearly income up to, but not exceeding $14,940 for an individual or $20,040 for a married couple living together (150% FPL as of 2/06.) Participants must enroll in one of the

	Medicare Prescription Drug Plans working with HoosierRx. Participants must apply with the Social Security Administration for extra help from Medicare. HoosierRx can assist those that get partial extra help from Medicare and those denied for Medicare's extra help due to resources.
Disabilities coverage	Persons with disabilities under age 65 are not eligible for state benefits, as of 11/05.
Benefit example	HoosierRx will help low-income seniors make up the difference between their out-of-pocket costs and the Medicare coverage. For individuals with partial Medicare extra help, HoosierRx will pay the remaining premium amount, that is not covered by Medicare, within one of the plans that are working with HoosierRx. HoosierRx will also pay a maximum of $250 yearly toward a $50 deductible and/or co-pays. For individuals with no Medicare extra help, HoosierRx will pay the monthly premium of one of the plans working with HoosierRx. HoosierRx will also pay $250 yearly toward a deductible and/or co-pays.
Special features	HB 1325 seeks coverage for Medicare deductibles, premiums and drug costs not covered by the federal benefit or federal PDP plans. HoosierRx currently does not require the use of prior authorization, preferred drug lists or mandatory generics. The 2005 law authorizes future coverage up to 200 percent of federal poverty if recommended and approved. A separate program, "**Rx for Indiana**" is a collaborative effort by Gov. Mitch Daniels, numerous local and statewide organizations and the pharmaceutical industry and is not a subsidy program, but rather a clearinghouse that pulls together all federal, state and private companies that offer discounted drugs and services. Rx for Indiana helps people of all ages find and apply for assistance through pharmaceutical manufacturers for help with brand name drugs. Each company program has different benefits and covers different drugs, providing free or discounted prescription drugs to eligible patients.
Requirements & Limits	The maximum annual benefit is $1,200; the state pays up to 75% of drug costs, the enrollee is responsible for the remaining 25%. In order to be eligible for HoosierRx, enrollee is required to apply for the "Medicare Extra Help" through Social Security to pay for Medicare Part D, and must receive either a "Notice of Award" or "Notice of Denial" from Social Security. A "Notice of Denial" must be because resources are above the limit established by law and a "Notice of Award" must state that enrollee is receiving a partial extra help subsidy to help pay for Medicare Part D premium. NEW
SPAP legal status	Not currently certified as a qualified SPAP; payments do not count toward enrollee TrOOP according to CMS, as of 11/8/05.
Est. # of beneficiaries NEW	1,500 enrollees as of 7/1/06 (no non-Medicare, no full dual-eligibles). The program anticipates increased enrollment by 12/06. As of 7/11/06, the Rx for Indiana telephone hotline logged 76,649 calls and the website logged 99,148 hits. 141,592 patients initially qualified for assistance and approximately 81% were eventually matched to a program.
Funding source	Money from the Tobacco Settlement Fund has been allotted for this program for the next three years, after which the Indiana Legislature must allocate budget money for an additional 20 years. Hoosier Rx currently receives no funding from the Indiana General Fund.
2006 & future issues NEW	HoosierRx has restructured the program and, as of 7/1/06, there is no more wrap around benefit ($250 for co-pays and premium). HoosierRx will now pay a higher premium amount for enrollees instead of using the wrap around benefit.
Contact & information Web site	Hoosier Rx Program (toll free) at 1-866-267-4679 Senior Health Insurance Information Program counselors (toll-free) at 1-800-452-4800. http://www.in.gov/fssa/elderly/hoosierrx/ NEW http://www.rxforindiana.org/

Updated: 12/29/05, 1/31/2006 & 7/17/06
Source: Hoosier Rx website (12/29/05); Interview with Governor's office 12/29/05 and ; HB 1325; HB 1251; IAC Title 405, Art. 6; e-mail and telephone correspondence with Brian Smith, PhRMA.

KANSAS	**Medicare-Medicaid dual-eligible Copayment plan** NEW
The Kansas Medicaid program is reported to pay limited state assistance with the cost of copayments to Medicare-Medicaid dual-eligible enrollees*	
State law(s)	Kansas Medicaid agency
Eligibility	Medicaid dual-eligibles under 135% of federal poverty.
Benefits	Medicaid will pay the $1 to $5 Rx copayments.
Special features	The terms of this limited benfit were first reported by NASMD in November 2006.* Other details are not available at the time of this update or have not been confirmed by NCSL.
Est. # of beneficiaries	
2006 and future issues	
Contact information NEW	Kansas Medical Assistance, http://www.srskansas.org/ISD/ees/eanddmedical.htm

Updated: 11/15/06
Source: * National Association of State Medicaid Directors (NASMD) report, "State Perspectives on Emerging Medicaid Pharmacy Policies and Practices" 11/06.

KENTUCKY	**Kentucky Pharmaceutical Assistance Program**
Kentucky passed a 2005 law to implement a state pharmaceutical assistance program. However, it has not been implemented. The state intended to contract with a third party, to direct dual or lower income beneficiaries into the state preferred plan. The contractor would negotiate for drug rebates. However, CMS clarified that these types of arrangements did not meet the criteria of an SPAP under Medicare. Kentucky has not moved forward with the SPAP as of January 1, 2006.	
State law(s)	2005: SB 23 signed into law March 18, 2005
Eligibility	Includes persons 65 or older or disabled and enrolled in Medicare, with a household income up to 150% of the poverty level, meeting the asset test, and not having other prescription drug coverage.
Benefit best example	**This program is not operational as of August 2006** and the start date is not yet established.
Special features	Would allow the Department of Medicaid Services to determine drugs to be covered by the plan, and allow department to negotiate with manufacturers for rebates.
Requirements & Limits	A memo from CMS Deputy Administrator Leslie Norwalk to potential Part D Sponsors and State Medicaid Directors stated that the types of arrangements with rebates and a preferred plan did not meet the criteria of an SPAP under Medicare. By state law, benefits are to be limited to the amount of state appropriations, with the program as a payor of last resort.
Est. # of beneficiaries	none enrolled
Funding source	State funds, subject to annual appropriation.
2006 & future issues	Features not approved by CMS in 2005 prevented implementation. The legislature likely will review such terms and conditions.
Contact & information Web site	Not available; not yet operational. Department of Medicaid Services

Updated: 1/1/06

MAINE	Low Cost Drugs for the Elderly and Disabled Program
Maine has run one or more senior pharmacy assistance programs since 1975. For 2006, the state will offer wrap around benefits for Medicare eligibles, including coverage for premiums, one-half of the deductible and 80% of the coverage gap.	
State law(s)	2005: LB 1325, signed by governor as Chapter 401, 6/17/05; State agency given emergency regulatory authority
Eligibility	For subsidized benefits: Maine residents age 62 and older, or persons with disabilities age 19-61, with annual income of $18,130. If a person spends 40% of yearly income on prescription drugs, the income limit is 15 percent higher. ($20,850 as of 2/06.) Income limits are $1,476/month (individual) and $1,978/month (couple).
Emergency gap coverage - 2006	As of Jan. 10, 2006, Maine reopened previous eligibility files (Medicaid or state pharmacy assistance program) if Medicare Part D eligibility is not determined. They are doing this with "existing funds" with a "promise" from regional CMS that the state will be reimbursed.
Disabilities coverage	Persons with disabilities under age 65 are eligible for state benefits, including coverage during the 2-year waiting period for federal Medicare eligibility.
Benefit example	Wrap around benefits apply to dual eligibles & three levels based on income. Some pharmaceuticals excluded by Medicare will continue to be covered for everyone, as covered in 2005. The state will pay 1/2 of the copay up to $10 - $15 for all dual eligibles. For those in assisted living, the state will pay 100% of all copays. The program has eliminated its asset limit, which will qualify an estimated 9,000 new residents. Those residents for whom the state pays Part B Medicare premiums, the state also will now cover Part D premiums. Copays are covered 50% with a cap of $10; also will cover 100% premium; 50% of deductible; and 80% of the coverage gap (doughnut hole), for the 14 categories of treatments specified in state law. Enrollees pay 20% of the coverage gap (over $2,250).
Special features	The Department of Human Services has emergency regulatory authority to make further adjustments in benefits and eligibility. In April '06, a Supplemental Budget was enacted with broad bipartisan support. It includes $10.7 million to ensure that seniors who received prescription drug benefits under MaineCare or the state's Drugs for the Elderly program would not lose benefits or have to pay more because they were switched to the federal Medicare Part D program. The budget provides extensive ongoing wraparound benefit for Medicare Part D enrollees including both Medicaid dual eligibles and participants in the state elderly low-cost drug program members who are transitioning to Medicare Part D. Also provides for the state purchase of a higher than benchmark plan when a person needs a drug that is not on their plan's formulary and they have an initial denial of an exception for coverage; eliminates all co-payments for persons in all levels of private non-medical institutions (boarding and group homes); and eliminates all co-pays on generics.
Requirements & Limits	
SPAP legal status	Qualified SPAP approved by CMS; payments count toward enrollee TrOOP, 10/05
Est. # of beneficiaries NEW	38,239 enrollees, as of 7/10/06 (approx. 28,000 enrolled in Medicare Part D) 47,867 dual-eligibles matched as of June 2006
Funding source	State appropriations.
2006 & future issues	The benefit details were not specified in statute in 2005, so proposed changes are possible during the 2006 session.
Contact & information Web site	Tel.: 207 287-2674; toll-free: 888 600-2466 http://www.maine.gov/dhhs/beas/medbook.htm

Updated: 12/15/05 & 7/17/06

Sources: Chapter 401 of 2005; Interview with Jude Walsh, Maine Special Asst for RX, 12/15/05 and 7/11/06.